Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Insurance Enrollment and Change Form

(FORM -1)

PLEASE TYPE OR PRINT CLEARLY

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		___/___/___	/

Name - Last | First | MI

Address: (Number and Street) This is a new Address ☐

City | State | Zip Code | Foreign Country

Date Entered Service: ____/____/____ | Bargaining Unit | Union Name

HR/CMS or UMASS Employee ID# | Home Phone ( ) | Work Phone: ( )

Spouse's Name | Spouse's Social Security number ___ ___ | Spouse's Date of Birth ____/____/____

02 ☐ **BASIC LIFE, HEALTH AND LTD COVERAGE**

New Enrollment ☐ Change ☐

Cancel Coverage: ☐ All ☐ Long Term Disablilty (LTD) ☐ Health Insurance ☐ Optional Life Insurance

EFFECTIVE DATE _____ / 01 /_____

☐ **Basic Life Only**

☐ **Long Term Disability (LTD)**

☐ **Basic Life and Health**
(Select one of the Health Plans below)

Annual Salary: $ _____

Salary Effective Date: ____/____/____

Health Plan		Plan Type
☐ Commonwealth Indemnity Plan CIC: ☐ Yes ☐ No		☐ Individual ☐ Family
☐ Commonwealth Indemnity Plan PLUS	☐ Commonwealth Indemnity Community Choice ☐ Harvard Pilgrim POS	
☐ HMO: _____ (write in the name of the HMO)	☐ Navigator by Tufts Health Plan	

Optional Life

Please Check One:

☐ Automatic Increase
Indicate Multiple Factor (1-8): _____

☐ Non Automatic Increase
Amount $: _____
No more then $ 1,000 less than annual salary rounded down to the nearest $ 1,000

Please Check One:

☐ Smoker

☐ Non-Smoker
Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates

- New Employees: Multiple Factor of 5-8 times requires a G6S form (Short Form Medical).
- Increasing Multiple Factor requires a G6 form (Medical Evidence of Insurability).
- Multiple Factor of 2-8 times is allowed only with Automatic Increase.
- Changing from Non-Automatic to Automatic increase requires a G6 form.

☐ 03 **Name Change** | Previous Name: | New Name:

LEAVE OF ABSENCE

04 ☐ **Leave Is:** With Pay ☐ Without Pay ☐

GIC USE ONLY: Leave Pay Status: Part ☐ Full ☐ Other ☐

Leave Type (You MUST Check one of the following):

____ Educational	*____ Industrial Accident	*____ Personal Illness	____ Suspension
____ Family (for dep < age 3)	*____ Maternity	____ Personal Reason	____ FMLA
____ Family (for dep > age 3)	____ Military	____ Sabbatical	____ Other

*Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date: ____/____/____ End Date: ____/____/____

Last Day on Payroll: ____/____/____

05 ☐ **Return to Payroll Deduction**: First Day Back in Payroll: ____/____/____

INSURED CHANGES

06 ☐	**Retirement**	Date Retired ____/____/____	
07 ☐	**Transfer to another Agency**	Name of Agency Transferred to	Effective Date
08 ☐	**Transfer from another Agency**	Previous Agency	Effective Date
09 ☐	**Termination**	Termination Reason	Termination Date ____/____/____

Coverage (if elected)

☐ 39-Week Coverage ☐ COBRA (must complete COBRA application)
☐ Deferred Retiree ☐ Conversion (contact carrier for application)

Long Term Disability Insurance (LTD)
I understand that by not applying to be insured for Long Term Disability insurance available to me, I may not apply for Long Term Disability insurance until I have provided satisfactory medical evidence of insurability.

Optional Life Insurance
I understand that by not applying to be insured for the maximum amount of Optional Life Insurance available to me, I may not increase my Optional Life insurance until I have waited at least one year from the original effective date and satisfactorily pass a medical examination.

Deduction Authorization
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

Retirement
I hereby certify that I have filed, or intend to file, an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans.

Termination
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

- If you are applying for Health Insurance, be sure to file a Form IDF to list family members
- If you are enrolling in HPHC POS or an HMO, be sure to file an application with the Plan.
- If you are applying for Life Insurance, be sure to file a Form 319 (or a G-500) to designate your beneficiary(ies).

x _____ Signature of Authorized Official | Date

x _____ Signature of Authorized Applicant | Date

FOR GIC USE ONLY

GIC Medical Approved	Political Subdivision	LTD Medical Approved
____/____/____		____/____/____

Entered | Verified

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR
RETIREES: RETURN COMPLETED FORM TO THE GIC

FORM 1 3/04 10,000

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Employee Acknowledgement Form

You are responsible for familiarizing yourself with your benefit options:

- Basic Life Insurance
- Basic Life & Health Insurance
- Optional Life Insurance
- Long Term Disability (LTD)
- Dental/Vision (if eligible)
- Health Care Spending Acount (HCSA)
- Dependent Care Assistance Program (DCAP)

Your signature is required on this form before your agency can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the *Benefit Decision Guide*. (Or for visually impaired employees, have listened to the BDG audio tape.)

I hereby acknowledge that I have reviewed the most recent *GIC Benefit Decision Guide* before I made my benefit elections.

Name: _____
(Please print)

Signature: _____

Social Security Number: _____

Date: _____

Employee: Return this signed form to your GIC Coordinator with your benefit elections.
GIC Coordinator: Retain original signed form in employee's personnel file.

3/2004

Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

INSURANCE DATA FORM (IDF)

PLEASE TYPE OR PRINT CLEARLY

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

INSURED INFORMATION:

1. Name: _____
Last First Middle

2. Address: _____
Street

_____
City State Zip Code

3. Social Security Number: _____ 4. Date of Birth _____ 5. Sex ☐ M ☐ F
Month Day Year

6. Health Plan Selection: ☐ Commonwealth Choice ☐ Commonwealth Indemnity ☐ Commonwealth Indemnity PLUS ☐ Commonwealth Indemnity Community Choice
☐ Navigator By Tufts Health Plan ☐ Harvard Pilgrim POS
☐ HMO Name:

7. Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

SPOUSE/DEPENDENT INFORMATION:

List below all family members, including your spouse, who will be covered under your family plan. Please provide all **exact** dates of birth for each dependent. Coverage for all children ends at age 19 , except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. Attach separate sheet if additional space is required.
Important: You are required to provide a copy of a marriage certificate, birth certificate, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION:

Is your spouse employed? ☐ Yes ☐ No Name of employer _____

Address of employer : _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

Name of insurance company _____ Policy/Certificate Number _____

Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan?

You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No

If yes, Medicare claim number _____

FORMER SPOUSE:

Name: _____
Last First Middle

Address: _____
Street

_____
City State Zip Code

Social Security Number _____ Date of Birth _____ Date of Divorce _____

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

TO BE COMPLETED BY GIC COORDINATOR: **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____

Agency Name _____

Agency Address _____ Agency Telephone Number _____

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Insured GIC-ID:	Agency/Division
– –	/

Insured Name: First	M.I.	Last

Street Address

City	State	Zip Code

YOU MUST READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM – PRINT CLEARLY IN CAPITAL LETTERS

BENEFICIARY #1

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

BENEFICIARY #2

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

BENEFICIARY #3

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

I hereby make the above designation of beneficiary revoking any and all previous beneficiary nominations and make the above nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policy(ies). I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiary(ies) as survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order; to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

Signature of Insured _____ Date _____

PLEASE MAKE A COPY OF THIS COMPLETED FORM AND FILE WITH YOUR IMPORTANT RECORDS AND PAPERS.

FOR GIC USE ONLY

Beneficiary Change

Please return to address shown on reverse side.

Commonwealth of Massachusetts ■ Group Insurance Commission
P.O. Box 8747 ■ Boston, MA 02114-8747

PLEASE READ ALL INSTRUCTIONS AND EXAMPLES CAREFULLY BEFORE COMPLETING THIS FORM.

INSTRUCTIONS

1. Please print all beneficiary information clearly in capital letters on the lines provided, indicating your beneficiary's name, relationship, address and the percentage of proceeds to be paid to each beneficiary. Incomplete forms will be returned. Refer to the samples illustrated to the right to assist you in the completion of your form.

2. If you do not provide a percentage of proceeds for your beneficiaries, the proceeds will be divided equally among all listed beneficiaries. If you provide a percentage for some but not all of the listed beneficiaries, your form will be returned to you to complete. **DO NOT PUT A DOLLAR AMOUNT IN THE *"% of Proceeds"* BOX.**

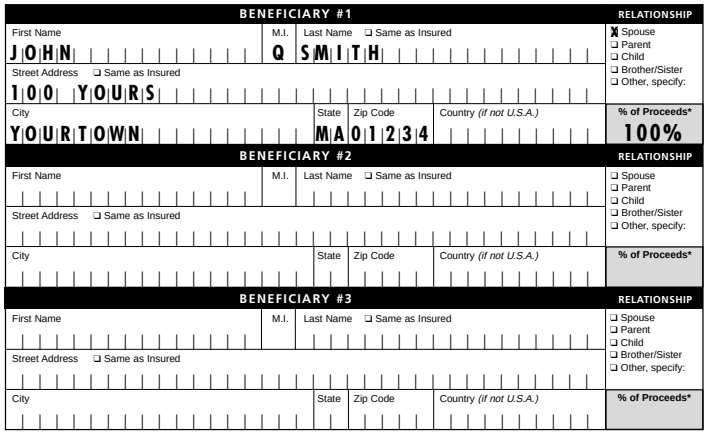
3. Use this form to designate up to three beneficiaries. If you wish to list more than three beneficiaries, **DO NOT** use this form. Instead, you must obtain a Nomination of Beneficiary form (G-500) from the GIC Coordinator at your worksite and use that form to list all your beneficiaries. If you are a retiree and need a G-500, please call (617) 727-2310 Ext. 801.

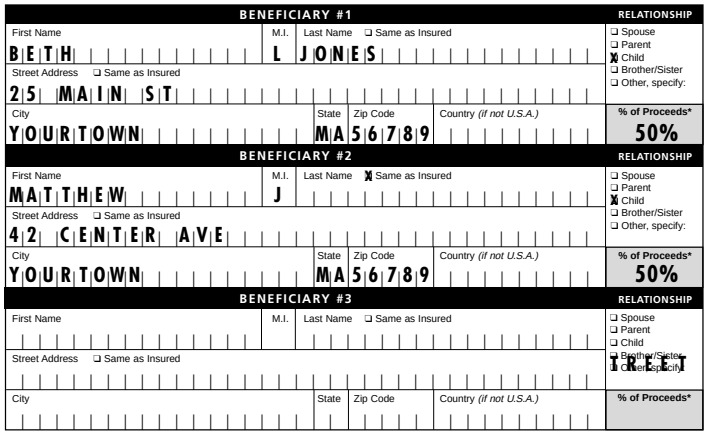
4. If you list beneficiaries who have the same last name as you, **DO NOT** write their last name. Instead, simply mark an ***"X"*** in the *"Same as Insured"* box for each beneficiary who has the same last name as yours.

5. If you list beneficiaries who live at the same address as you, **DO NOT** write in their address. Instead, simply mark an ***"X"*** in the *"Same as Insured"* box for each beneficiary who lives at your address.

6. Please sign and date the form clearly, in ink, where indicated. Keep a copy of the completed form with your important papers.

7. Please return this completed form to the Group Insurance Commission.





- If you list two or more beneficiaries with a specific percentage designated to each, proceeds will be paid as you designated. If one of the beneficiaries dies before you, proceeds will be paid to the remaining beneficiary(ies).
- If you list more than one beneficiary and indicate 100% for each one, this means that when you die, the first beneficiary will receive 100% of the proceeds. However, if the first beneficiary dies before you, the second designated beneficiary will receive 100% of the proceeds. If the second beneficiary also dies before you, your third beneficiary will receive 100% of the payment.
- If all designated beneficiaries die before you, payment will be made according to the terms of your life insurance policies in effect at the time of your death.

PLEASE COMPLETE FORM ON THE OTHER SIDE.

Commonwealth of Massachusetts
Group Insurance Commission

The Commonwealth of Massachusetts
Group Insurance Commission

P. O. Box 8747
19 Staniford Street
Boston, Massachusetts 02114-8747
(617) 727-2310

NOMINATION OF BENEFICIARY

Insured GIGID _ _		**Agency Name**
Insured Name: First	**MI**	**Last**
Street Address		
City	**State**	**Zip Code**

I hereby make the following designation of beneficiary, revoking any and all previous beneficiary nominations, and make the following nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policy(ies). I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiary(ies) as survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order: to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

Please print below each beneficiary's name, address, relationship to you and percentage of proceeds. Be sure to sign and date the form. PLEASE PRINT CLEARLY

Beneficiary: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Insured: _____	**Date:** _____

Please make a copy of the completed form to keep with your important records and papers.

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Commonwealth Indemnity Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at 1.617.727.2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, UNICARE, the administrator of the Commonwealth Indemnity Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or UNICARE when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling UNICARE's Commonwealth Service Center at 1.800.442.9300.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see the GIC's website: www.mass.gov/gic

3/04

Commonwealth of Massachusetts
Group Insurance Commission

Commonwealth Indemnity Plan
STATEMENT OF
VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the Commonwealth Service Center. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify UNICARE's Commonwealth Service Center when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE
(COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
UNICARE, Commonwealth Service Center
PO Box 9016
Andover, MA 01810-0916

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

3/04

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Navigator by Tufts Health Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification For Student Coverage" prior to the dependent's 19th birthday. If you are interested in applying for student coverage, complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/ Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, Tufts Health Plan, the administrator of the Navigator Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or Tufts Health Plan when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling Tufts Health Plan at 1.800. 870.9488.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website www.mass.gov/gic

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS NAVIGATOR STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the Tufts Health Plan. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify the Tufts Health Plan when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Tufts Health Plan, Attn: Commonwealth of MA Enrollment
705 Mount Auburn Street, PO Box 9186
Watertown, MA 02471-9186

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

3/2004

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Harvard Pilgrim Health Care POS Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification For Student Coverage" prior to the dependent's 19th birthday. If you are interested in applying for student coverage, complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, Harvard Pilgrim Health Care will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or Harvard Pilgrim Health Care when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling Harvard Pilgrim Health Care at 1.800.542.1499.

We can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website www.mass.gov/gic

3/2004

Commonwealth of Massachusetts
Group Insurance Commission

HPHC POS STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to Harvard Pilgrim Health Care. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify Harvard Pilgrim Health Care when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Harvard Pilgrim Heatlh Care, Account Services GIC Student Coordinator
P.O. Box 9185
Quincy, MA 02269

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

3/2004

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

HMO Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, the Group Insurance Commission will determine student coverage eligibility and effective dates. Once this application has been approved by the GIC, your HMO will contact you every spring and every fall thereafter to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify the Group Insurance Commission when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from the Group Insurance Commission. You may also receive information concerning these options by calling the Group Insurance Commission at (617) 727-2310.

We can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website:
www.mass.gov/gic

3/2004

Commonwealth of Massachusetts
Group Insurance Commission

HMO STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the GIC. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify the GIC when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Group Insurance Commission, PO Box 8747, Boston, MA 02114-8747

III. FOR GIC USE ONLY

Insured Parent's Coverage_____ Effective Date ___/___/___ Agency/Division_____/_____

Status

Approved_____ Effective Date___/___/___Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION

PRE-TAX BASIC LIFE & HEALTH INSURANCE PLAN

The Commonwealth has adopted the State Pre-Tax Basic Life & Health Insurance Plan to save you money on your insurance premiums. Under this Plan, if you have basic life or basic life and health insurance through the Group Insurance Commission, your premiums will be deducted from your salary on a pre-tax basis. This means that you will not have to pay state or federal income taxes on your share of the cost of basic life and health insurance premiums, which will result in a slightly larger paycheck. This will not affect your current insurance benefits; coverage will remain the same.

This benefit is automatic, no further action on your part is required to receive this benefit.

Federal law, however, requires that you be offered the opportunity to decline this benefit. If you elect not to participate in this plan you may not change your mind until an annual enrollment period, or unless or until one of the following occurs:

1. you get married or divorced;
2. the birth or adoption of a child;
3. your spouse or dependent dies;
4. your spouse commences or is terminated from employment;
5. you or your spouse take an unpaid leave of absence;
6. you involuntarily lose health insurance through no fault of your own.

If you decide not to participate in this plan you must complete the other side of this Election Not to Participate Form and submit it to your GIC or Payroll Coordinator. If you do not submit a completed form, your insurance premiums will be deducted on a pre-tax basis automatically.

Commonwealth of Massachusetts
Group Insurance Commission

COMMONWEALTH OF MASSACHUSETTS

GROUP INSURANCE COMMISSION

Pre-tax Basic Life & Health Insurance Plan
Election Not to Participate Form

YOU MUST READ PAGE ONE BEFORE COMPLETING FORM - PRINT CLEARLY IN CAPITAL LETTERS

Social Security Number		**Agency/Division**	
Insured Name:	**First**	**M.I.**	**Last**
Street Address			
City		**State**	**Zip Code**
Signature of Insured			**Date**

I hereby elect NOT to participate in the state Pre-Tax Basic Life & Health Insurance Plan. I understand that by making this election I have chosen to have my share of basic life and basic health insurance premiums paid on an after-tax basis. I understand that as a result of this election not to participate in the plan, I will not receive an increase in “take home pay.”

I further understand that I may not change this election until an annual enrollment period or unless one of the following “change in family status” occurs:

1. I get married or divorced;
2. A child is born to me, or I adopt one;
3. My spouse or one of my dependents dies;
4. My spouse commences or is terminated from employment;
5. I or my spouse take an unpaid leave of absence; or
6. I involuntarily lose my health insurance coverage through no fault of my own.

3/2004

Commonwealth of Massachusetts
Group Insurance Commission

Dental and Vision Enrollment and Change Form (FORM -1)

FOR MANAGERS, CONFIDENTIAL EMPLOYEES, THE LEGISLATURE, CONSTITUTIONAL OFFICES AND THEIR STAFF ONLY. EMPLOYEES SUBJECT TO COLLECTIVE BARGAINING AND EMPLOYEES IN HIGHER EDUCATION, THE JUDICIAL COURT SYSTEM, AND OF AUTHORITIES ARE NOT ELIGIBLE

PLEASE TYPE OR PRINT CLEARLY

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		___ / ___ / ___	/

Name - Last First MI

Address: (Number and Street) This is a new Address ☐

City	State	Zip Code	Foreign Country

Date Entered Service:	Home Phone:	Work Phone:
____ / ____ / ____	( )	( )

02 **NEW ENROLLMENT** ☐ **PROMOTION** ☐ **CHANGE** ☐ **CANCEL COVERAGE** ☐

EFFECTIVE DATE ____ / 01 / ____

Type of Coverage

Individual ☐ Family ☐

Dental Benefit (Please check One)

☐ Indemnity Plan (DeltaPremier)
☐ PPO Plan (DeltaPreferred)

I understand that I may not change this plan type until the next annual enrollment period.

Vision Benefit (Select Provider at Time of Service)

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

List below all family members, including your spouse, who will be covered under your dental and vision family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. Attach separate sheet if additional space is required.

Important: The Group Insurance Commission reserves the right to require you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent. This proof may be requested at any time.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective Date: _____

03 ☐ **Name Change** Previous Name: New Name:

LEAVE OF ABSENCE

04 ☐ **Leave Is:** With Pay ☐ Without Pay ☐ **GIC USE ONLY:** Leave Pay Status: Part ☐ Full ☐ Other ☐

Leave Type (You MUST Check one of the following):

____ Educational	*____ Industrial Accident*	*____ Personal Illness	____ Suspension
____ Family (for dep < age 3)	*____ Maternity	____ Personal Reason	____ FMLA
____ Family (for dep > age 3)	____ Military	____ Sabbatical	____ Other

*Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date: ___ / ___ / ___ End Date: ___ / ___ / ___

Last Day on Payroll: _____ / _____ / _____

05 ☐ **Return to Payroll Deduction**: First Day Back in Payroll: _____ / _____ / _____

INSURED CHANGES

06 ☐	**Retirement**	Date Retired ____ / _____ / ____		
07 ☐	**Transfer to another Agency**	Name of Agency Transferred to	Effective Date	
08 ☐	**Transfer from another Agency**	Previous Agency	Effective Date	
09 ☐	**Termination**	Termination Reason	Termination Date	____ / _____ / ____

PLEASE READ CAREFULLY

Eligibility: I understand that only managers, confidential employees, the legislature, constitutional offices and their staff are eligible for this program. I am an employee that falls into one of these categories and I am not employed by higher education, the judicial court system, and/or an authority.

Deduction Authorization: I authorize my employer to deduct from my payroll check the amount required for the dental and vision coverage I have selected.

x _____ _____
Signature of Applicant Date

x _____ _____
Signature of Authorized Official Date

FOR GIC USE ONLY

ENTERED	VERIFIED	

RETURN COMPLETED FORM TO YOUR GIC COORDINATOR